Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	: **MUHAMMAD IRFAN MUHAMMAD ZAMEER**
Card No	: **I022-029-119647410-01**
Policy Holder	: **MUHAMMAD IRFAN MUHAMMAD ZAMEER**
Payer Name	: **TAKAFUL EMARAT**
TPA	: **E CARE - Blue Network**
Validity	: **19-09-2024** To **18-09-2025**
Gender	: **Male**
Date Of Birth	: **02-Jul-1988**
Patient's Tel No	: **0558209860**

Service Date:20-Jan-2025 **Network** : Green

Health Provider :**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name :**SANDIA**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : pc : loose stool vomiting conatining food particles no fever o/e dry oral mucosa **Duration:**

Vitals: Temp : 36 Bp :128 Pulse :75 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding, **Date of Onset** : 20/25/2025

Requested Investigations: 0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION,96360, HYDRATION IV INFUSION INIT,0102-152902-1001, LACTATED RINGERS INJECTION USP-(CALCIUM CHLORIDE : N/A) (POTASSIUM CHLORIDE : N/A) (SODIUM CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP,0005-174202-0781, RISEK 40MG-(OMEPRAZOLE : 40 MG) POWDER FOR INFUSION,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated : Cost**

Prescriptions: 0699-200001-1451 - (LOPERAMIDE : 2 MG CAPSULES (HARD GELATIN,0097-708002-0831 - (TRISODIUM CITRATE DIHYDRATE : 0.58G) (POTASSIUM CHLORIDE : 0.3 G) (SODIUM CHLORIDE : 0.52 G) (DEXTROSE ANHYDROUS : 2.7 G) POWDER FOR SOLUTION,0240-223401-1171 - (NAPROXEN : 500 MG TABLETS,0005-150407-1172 - (METOCLOPRAMIDE : 10 MG TABLETS,0248-187801-1171 - (DILOXANIDE FUROATE : 250 MG) (METRONIDAZOLE : 200 MG) TABLETS, **Estimated : Cost**

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : SANDIA **Stamp :**

Dr. Sandia Bhojwani
General Practitioner
DHA No: 65900212-001
PESHAWAR MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 20-Jan-2025

Signature : **Date** : 20-Jan-2025